Frequently Asked Questions

Verifying Medicaid Recipient Eligibility Training

Bureau of Medicaid Services &
Area Medicaid Program Offices
Last Updated-November 13, 2011
All Medicaid handbooks, fee schedules, forms, provider notices, and other important Medicaid information are available on the Medicaid fiscal agent’s Web Portal at: http://mymedicaid-florida.com/

- Select Public Information for Providers
- Select Provider Support
- Select Handbooks, Fee Schedules, or Forms
COPAYMENT

- We have patients who have a $2.00 copayment. However, the Web Portal does not provide information about copayments.

Information on Medicaid’s copayment requirement can be found in the Florida Medicaid Provider General Handbook in Chapter 1, beginning on page “1-9.” The information includes a chart showing the services with copayments and the amount. You will also find that some recipients are exempt from paying the copayment. In these cases the copayment amount is not deducted from your payment. The largest exempt group is children under age 21.

- Is the $2.00 copayment still only one copayment per day? If recipients see more than one provider per day how would we know not to collect the $2 copayment?

Copayments are one co-pay, per provider (or provider group), per day. If a recipient received services from two providers in a group on the same day, he would only have one copayment. If the same person received services from two separate practices on the same day, he would be charged the copayment by each. For example, $2.00 for Home health services, per provider, per day. Or $1.00 for non-emergencies transportation services, each one-way trip. See more detailed information in the Florida Medicaid Provider General Handbook, Chapter 1; beginning on pages "1-9."
Patients that are enrolled in a Medicare Advantage Plan still think that they have Medicaid second. What can we do to help us and them?

Florida Medicaid covers the Medicare Part C deductible and coinsurance up to the Medicaid fee, less any amounts paid by Medicare. If this amount is negative, no Medicaid payment is made. If this amount is positive, Medicaid pays the coinsurance and deductible up to the billed or allowed amount, whichever is less. The Florida Medicaid system is in the process of being programmed to comply with the state’s policy governing Medicare Advantage plan copayments. The system changes will be retroactive to January 1, 2010.

Can you clarify if Medicaid only covers Medicare part B premium? Is the patient responsible for the 20% coinsurance?

If you are referring to persons who only have coverage as Special Low Income Medicare Beneficiaries (SLMB) or as Qualifying Individuals I (QI1), this would be correct, but note that it is possible for a person to be eligible for both SLMB and a full Medicaid coverage program at the same time. Crossover claims policy would apply for those persons. More information can be found in the Florida Medicaid Provider General Handbook in Chapter 3, on page “3-29.”

Slide 38 of the presentation states that full Medicaid over-rules lower programs. Then, on slide 61 it states that as the recipient is QMB along with full Medicaid, the provider can bill for level of care (Medicare coinsurance). Could you please clarify this issue?

The QMB coverage means that the person has Medicare (another payer) in addition to the Medicaid coverage. The “level of care” refers to Nursing Facilities. Even though this person does not have the Long Term Care Medicaid, they have Medicare that could pay for Nursing Facility days (up to a limit). In this case the facility can bill Medicaid for part A coinsurance only – level of care = X. Of course, during the process of verifying eligibility, you would have already seen the Medicare coverage information.

SLMB: What is the definition of a Medicare Premium?

The Medicare premium is the amount that a person with Medicare Part A and/or Medicare Part B pays to Medicare to receive coverage.
- Can you go over reimbursement for Share of Cost Medicaid patients? Is Medicaid now paying the full 20% after Medicare pays 80% of their allowed amount?

Information on Medicaid reimbursement for persons with both Medicare and Medicaid (dual eligibles) can be found in Chapter 4 of the **Florida Medicaid Provider General Handbook**. Claims with Medicare as the primary payer are called crossover claims. In the section labeled “Medicaid Program Limits,” you will find the information on how Medicaid reimburses crossover claims. If the Medicare payment is greater than the Medicaid payment for the same procedure, you must accept the Medicare payment as “payment in full.” You cannot “Balance Bill” or require any additional payment from the recipient.
Medically Needy (Share of Cost)

- Can you please let me know how to check eligibility on share of cost patients?

A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid's income or resource limits. A Medically Needy recipient becomes eligible on the day that the recipient incurs allowable medical expenses that equal or exceed the amount by which his income exceeds the Medicaid income standard (share of cost).

Recipients with a Share of Cost should be treated as private pay patients until they meet the Share of Cost amount. They should be informed that they will be responsible for the charges if they do not incur enough medical expenses to meet the Share of Cost. Information on the Share of Cost amount can be provided by the recipient or the Department of Children and Families (DCF).

- Is DCF the only agency that determines share of cost?

Yes. Enrollment in the Medically Needy program only happens with DCF determinations. There is no similar program for SSI determinations through the Social Security Administration. Their applicants are either eligible for full coverage or not at all.

- What is “Share of Cost” Medicaid?

When eligibility for Medicaid is determined, some people will meet all the technical requirements except that their income or the value of their assets (resources) is too high. These people can be enrolled in the Medically Needy program. The difference between the person’s income and the qualifying limit for full Medicaid is their “Share of Cost” (SOC).

For example, if the income limit for a person to get full Medicaid is $350/month and the person makes $500/month, this person’s SOC would be $150. Any month that this person’s medical expenses are more than $150, the person will get Medicaid coverage. Coverage will begin on the day the SOC is met and continues to the end of the month. Persons enrolled in Medically Needy will not be listed when you try to verify eligibility unless medical bills or other proof of medical expenses have been sent to the appropriate DCF office. DCF uses the bills to establish the date when the person is Medicaid eligible. Please contact your Area Medicaid Office for information on sending bills to DCF for tracking. You can find a list of the Medicaid Area Offices and contact information on the Medicaid fiscal agent's Web Portal at:

- Do we bill for share cost monthly or wait until monthly bills are submitted?

You can bill at any time after the person's eligibility is established for the month.

- How do we check how much a recipient has already met or needs to meet before being considered eligible for full Medicaid?

If the recipient cannot give you the information on his/her Share of Cost, you will need to get the information from DCF. You can use the DCF Provider View link from the secure area of http://mymedicaid-florida.com. You can also contact the DCF call center at: 1-866-762-2237 or send a written request at this web site: https://www.dcf.state.fl.us/contact/contact_email.shtml?recv=ACCESS.

- For SSI recipients, how are we able to obtain documentation that stipulates share of cost for a Skilled Nursing Facility in order to accurately bill for services secondary to Medicare?

Please contact the Department of Children and Families (DCF). Providers should email their DCF Customer Call Center to request information about a recipient's Patient Responsibility:

- Jacksonville: NFCCC_CCC@dcf.state.fl.us
- Tampa: sr_call_center@dcf.state.fl.us; or
- Miami: D11_SFL_CallCenter@dcf.state.fl.us.
MANAGED CARE

- How do we find out which network provider to call?

If you check eligibility through the web portal, look for this information in the Managed Care section of the recipient’s eligibility screen. You will find the name, type and phone number of the HMO, PSN or other managed care plan.

- Is the network provider the one who is going to give us the authorization for the services?

No, you would get the authorization from the Health Plan. The only time you will get authorization from a provider is for a person managed under MediPass.

- Referring to Slide 50: If recipients don’t have managed care, will it be blank or will it state FL Medicaid?

If the recipient does not have managed care, the Web Portal screen will show ***No rows found***.

- A patient will come in with a Medicare managed plan yet also show us a Medicaid card. The Medicaid eligibility will show full Medicaid benefits but does not show the Medicare Advantage plan yet we do call and verify eligibility with the Medicare HMO. Does Medicaid pay as a secondary in this case?

Medicaid is not currently paying crossover claims for beneficiaries in Medicare HMOs (Part C plans), but there are changes in the works that may take place as soon as the end of the year. Please watch for any upcoming provider alerts on this subject. You may also contact your Local Medicaid Area Office for questions on this topic. You can find a list of the Medicaid Area Offices and contact information on the Medicaid fiscal agent’s Web Portal at: [http://mymedicaid-florida.com/](http://mymedicaid-florida.com/)

- When is it allowable to bill the family if we are not informed about a change in Medicaid or a lapse in Medicaid eligibility? We do inform all parents from the beginning that they must inform us of insurance changes in order to avoid the family having to pay for the therapy. We have not charged anyone as of yet, although we are losing too much money with so many changes. We would like to bill the family if Medicaid will not pay. Is this appropriate and allowable?

It is the provider’s responsibility to verify Medicaid recipient eligibility every time you render a service. A change in eligibility or managed care status would be discovered when you verify eligibility. Information on when it is allowable to bill the recipient can be found in Chapter 1 of the Florida Medicaid Provider General Handbook on page “1-7.” When a recipient is in an HMO...
or other managed care organization, you must receive authorization from that managed care organization in order to receive payment from that managed care organization. If you find that a recipient is not Medicaid eligible or that Medicaid will not reimburse for the service you plan to provide, you must document in the patient record that you informed the patient they will be responsible for payment and their agreement to receive the services.

- If I have a situation where our claims are being underpaid with our HMO contract and we have sent several requests, spreadsheets and calls to get this rectified; what other recourse do we have as a provider?

The Medicaid contract requires that the provider address any claims/billing disputes through the provider complaint system of the individual Health Plan. Language from the contract is provided below. If the provider is unable to resolve this with the Health Plan, they are able to access an outside claims arbitrator, Maximus, which deals with claims disputes between Health Plans and providers. Application forms and instructions on how to file claims are available from Maximus. For information, call Maximus at 1-866-763-6395, and ask for Florida Appeals Process.

d. As a part of the provider complaint system, the Health Plan shall:
   (1) Have dedicated staff for providers to contact via telephone, electronic mail, regular mail, or in person, to ask questions, file a provider complaint and resolve problems;
   (2) Identify a staff person specifically designated to receive and process provider complaints;
   (3) Allow providers forty-five (45) calendar days to file a written complaint for issues that are not about claims;
   (4) Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider contract provisions, collecting all pertinent facts from all parties and applying the Health Plan’s written policies and procedures;
   (5) Ensure that Health Plan executives with the authority to require corrective action are involved in the provider complaint process.

e. The Health Plan shall provide a written notice of the outcome of the review to the provider.

- Though a recipient may be enrolled with a managed care plan such as a PSN, can Medicaid still be billed for certain outpatient services such as mental health services and be paid without it being an overpayment?

For most HMOs or Medicaid Reform plans, no. In the case of Provider Service Networks (PSNs), you can bill some PSNs directly, but for others you would bill the Medicaid fiscal agent. You should ask the PSN or your Medicaid Area Office. For recipients under a MediPass primary care provider, mental health services are provided through the Pre-paid Mental Health Plan. See next question.
A client has full Medicaid but has Pre-paid Mental Health Plan. Is this another/same type of HMO?

The Pre-paid Mental Health Plan is a managed care plan that provides mental health services to recipients who are in the MediPass Program. It operates similar to an HMO. The Health Plan is paid a monthly amount to cover mental health care for the member. Treating providers must be in the plan’s network and are paid by the plan, not directly by Florida Medicaid. Billing Medicaid fee-for-service for mental health services covered by the PMHP is not permitted. Please be advised that substance abuse services are not covered by the PMHP, and Medicaid providers may bill fee-for-service for substance abuse services.

Does Medicaid or Medicaid HMOs have policy limitations on assisted living facilities (ALF)s and/or skilled nursing facilities (SNF)s?

For information on Medicaid policy for SNFs and ALFs, please see the Nursing Facility Services Coverage and Limitations Handbook and the Assistive Care Services Coverage and Limitations Handbook. Medicaid recipients residing in a Skilled Nursing Facility are not eligible to enroll in a Medicaid Health Maintenance Organization (HMO). Individuals who are residents in ALFs and are not enrolled in the Assisted Living or Nursing Home Diversion waiver programs may enroll in the Medicaid HMOs.

How can I check for eligibility for a specific service by a managed care plan?

You may ask the recipient’s managed care plan when you contact them for authorization. If you do not have a specific recipient, you may contact the managed care plan for general information. Your Area Medicaid office may be able to provide the contact telephone numbers for the managed care plans in your county.

Does EBA always show prior to OTC? Can you please explain in more detail how EBA and OTC work on the portal?

OTC (Over the Counter) is not a benefit plan. It is part of the text in the description of what the Enhanced Benefit Account (EBA) covers. The purpose of the Enhanced Benefit Account (EBA) program is to offer incentives to recipients enrolled in a Reform plan to participate in wellness activities, also referred to as healthy behaviors. When recipients participate in approved healthy behaviors, they earn credits that can be used to buy over-the-counter health-related items at pharmacies. Recipients can earn a maximum of $125 in credits per state fiscal year (July 1 through June 30).

If a patient has full Medicaid benefits but is in an HMO program, do they quality for dental since there is not a dental HMO?
Some Medicaid HMOs cover dental services. If the HMO does not cover dental services, they may be covered by a Prepaid Dental Plan. Such plans currently operate in Miami-Dade, and they will expand statewide starting in 2012. If the person is not in a prepaid dental plan, the person would be covered under the fee-for-service Dental Services for Children or Dental Services for Adults. Note that the services for adults are very limited. Currently the following health plans cover optional (State Plan) dental services in all of their non-Reform counties of operation: JMH, Healthy Palm Beaches, Integral, Sunshine, and Molina. Beginning on January 1, 2012, only the following health plans will cover optional (State Plan) dental services: Healthy Palm Beaches, Integral, and Molina. Please be careful to request service authorization and to bill accordingly. Information on the implementation of the Statewide Prepaid Dental Health Plan program is available at the following website: www.AHCA.MyFlorida.com/MedicaidPDHP.
THIRD PARTY LIABILITY (TPL)

- When checking eligibility, sometimes, there is COMMERCIAL INSURANCE listed on the Medicaid website as primary payer. After checking the primary payer websites, I find that the commercial insurance has terminated - sometimes up to 8 months prior. What can I tell parents to do to get the commercial insurance removed, so that we can utilize their Medicaid coverage? Who do they need to contact? Who can they call? If you can please help us with this, it would be very much appreciated.

If a recipient has other insurance coverage through a third party source, such as Medicare, TRICARE, insurance plans, AARP plans, or automobile coverage, we refer to that as Third Party Liability (TPL). As you know, these other sources must be billed prior to billing Medicaid. Florida Medicaid currently contracts with Affiliated Computer Systems (ACS) to manage TPL operations. Providers who have questions or problems concerning third party insurance can contact the Medicaid third party contractor:
- By telephone at 877-357-3268 (FL-RECOV),
- By fax at 866-443-5559,
- Through the website at http://www.FLMedicaidTPLRecovery.com,
- By e-mail at FLMedicaidTPLRecovery@acs-inc.com,
- Or in writing to:
  ACS; Florida TPL Recovery Unit; 230; Killearn Center Blvd., Bldg A1; Tallahassee, Florida 32309
The TPL contractor can make the necessary corrections to the information on the recipients’ files.

- How do we handle patients with FULL MEDICAID who also have an individual plan (ex. BCBS) and they refuse to acknowledge the individual coverage. BCBS makes it a patient responsibility/deduct and then Medicaid paid for the service. What do I do?

Medicaid is always the payer of last resort. Other insurance, including Medicare, must be billed prior to requesting Medicaid payment. Florida Medicaid currently contracts with Affiliated Computer Systems (ACS) to manage Third Party Liability (TPL) operations. Providers who have problems concerning third party insurance information can contact ACS, and they will make the necessary corrections to the information on the recipients’ files. If the TPL approves the service, but does not make a payment because it is applied to the patient’s deductible the provider can bill to Medicaid with the TPL EOB and is entitled to received payment for the service up to the Medicaid fee.
MEDICAID ELIGIBILITY

- I was wondering how often the Medicaid numbers have to be run. It used to be the first of each month and then I have read weekly or even before each session. Please let me know what is necessary in order to eliminate missing a child who is switched to an HMO, has other third party insurance or, is no longer eligible.

Because Medicaid eligibility may change at any time, providers are encouraged to verify recipient eligibility prior to the delivery of any goods or services. A provider who chooses to verify eligibility on a periodic basis runs the risk of missing changes in eligibility. While we do not mandate a specific period of time, minimally, monthly verifications should be conducted for those recipient who receive routine goods or services; however, even with frequent verification if eligibility changed between verifications, the responsibility/risk is on the provider.

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- Slide 18, states: “It is the provider’s responsibility to verify a patient’s Medicaid eligibility prior to providing any Medicaid reimbursable services.” If a recipient is not eligible for the month of September until the 15th of the month (and then eligibility is retroactive for the entire month), but services were provided earlier in September… will those services be billable once the recipient becomes eligible for the month?

Yes, once the recipient has eligibility for the date of service. Keep in mind that if you provide services for a person who is not eligible, you should not expect Medicaid payment. The recipient must be informed and agree to receive services that may not be covered by Medicaid. See Page “1-7” in Chapter 1 of the Florida Medicaid Provider General Handbook. All Medicaid handbooks, fee schedules, forms, provider notices, and other important Medicaid information are available on the Medicaid fiscal agent’s Web Portal at: http://mymedicaid-florida.com/

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- How do I document verification of recipient eligibility?

You can obtain a call reference number through the AVRS. If you use the Web Portal you may choose to save a copy of the screen print or print out a hardcopy. If you use a MEVS vendor you will receive hardcopy when you verify eligibility that you can save.

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- To show proof that we verified eligibility, we use a spreadsheet with recipient name, Medicaid number, date checked and comment box. Is this enough to show or document verification of eligibility? We verify eligibility using the web portal.

Many providers print out or save a screen shot of the page when they look up the eligibility and put it with the recipient’s file. If there is ever a discrepancy at a later time with the recipient’s eligibility it will show what the provider saw at the time the provider checked the eligibility.
Will the system’s speed ever be improved? We have 60+ individuals to verify eligibility on. This process currently takes hours and hours to complete because the system response is so slow.

You may want to look into submitting batch transmissions. These can be done on the web portal or with most of the eligibility vendors. You can contact the fiscal agent for assistance with the web portal at www.mymedicaid-florida.com.

We use passport OneSource to verify eligibility on a monthly basis. There are times that the system is down. Is there any other source or program that we can verify eligibility? If so, how can we get access?

There are other options. The Automated Voice Response System (AVRS) works well for a small number of verifications or if you want to cross check the result from another source. The number is 800-239-7560. You will need your Florida Medicaid Provider Number or National Provider Identification to access. For a large number of verifications you can use the fiscal agent’s Web Portal to verify eligibility. Contact our fiscal agent’s Provider Inquiry line for assistance with this. The number is 800-289-7799, Option 7.

Keep in mind that there is one primary source for the Medicaid data. If your vendor’s system is down, it is possible that these other methods of verification will also be down.

We have about 400 Medicaid patients to verify every month. Will the fiscal agent’s Provider Inquiry line work for us?

Not for actual eligibility information since they limit the number that their operators will do per call. For that volume you may want to see if your current vendor can accept batch transmissions. The fiscal agent’s Web Portal can also accept batch transmissions. You can contact the Provider Inquiry line for help at: 800-289-7799, Option 7.

We have 150 recipients that receive services on a daily basis. Is there a way to check the eligibility of more than one consumer at time? How?

You may want to look into submitting batch transmissions. These can be done on the web portal or with most of the eligibility vendors. You can contact the fiscal agent at 800-189-7799, Option 7, for assistance with the web portal. You can find the list of the approved M.E.V.S. vendors at the link below. [http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_MEVSVendorList/tabld/63/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_MEVSVendorList/tabld/63/Default.aspx)
• Is there any other method that we can check eligibility that would not take up so much paper, time and space in folders and would validate that we checked eligibility?

The automated voice response system (AVRS) gives you an eligibility verification number to confirm your call. This may or may not be an option for you depending on the number of verifications you need to do. The available Medicaid Eligibility Verification System (MEVS) vendors may have some means of confirming transactions, but you would have to contact those companies to find out. The list of vendors is on the HP website at the address below:
http://portal.flmmis.com/FLPublic/Provider_EDI/Provider_EDI_MEVSVendorList/tabld/63/Default.aspx

• Is there a place where we can find descriptions of what the Program Codes mean?

Yes, you can find this in the Florida Medicaid Provider General Handbook in Appendix C (the very end of the book). Handbooks are on the fiscal agent's website at:

• How do I find a recipient's Medicaid program code?

The program code will be announced (for eligible recipients) with the eligibility information verified through the Automated Voice Response System (AVRS) or it will be displayed in the Benefit Plan section of the Web Portal eligibility screen.

• I would appreciate if you could clarify the difference between the MS category and the MMS category. I understand that MS is the primary SSI coding. If the Portal shows only MMS (with no other MS coding), is the member SSI eligible? The Handbook states that MMS is “MEDS for Aged or Disabled” (it does not specify SSI). I had previously called EDS and was advised by them that it is not an SSI eligible coding. As this continues to cause confusion, we would appreciate a definitive answer.

The information through our methods of verifying eligibility is only intended for Medicaid purposes. MS does indicate SSI Medicaid. MMS indicates an eligibility determination made by the Department of Children and Families for coverage under the MEDS category. Both are full Medicaid coverage codes.

• How can we get information on the income guidelines of a family to see if they are eligible for Medicaid/food stamps before we send them to apply for services?

You (or the family) can go to the DCF website at the link:
http://www.myflorida.com/accessflorida/ and click on the box labeled “Prescreening”. This is a
tool to see if they may be eligible for Food Assistance, Cash Assistance or Medicaid. The application process can also be started on the same page.

- What is the easiest way to find out a newborn’s Medicaid number? No given name yet, only date of birth because no SS yet either.

This information is not available through the eligibility verification methods we presented during the training. If you have the mother’s Medicaid number, your Medicaid Area Office can use it to find her DCF case number. With that case number, you can contact DCF to have them look up the mother’s case. The newborn’s Medicaid number should be available from them. Once you have the child’s Medicaid number, you can verify eligibility through the normal methods.
ELIGIBILITY AND WAIVERS

- As a Medicaid Waiver Provider under the Home and Community Based Waiver, if we receive a Service Authorization from the Waiver Support Coordinator authorizing us to provide services, do we have to go to FIMMIS and check eligibility for every single day, that we provide services, or can we check eligibility once a month? Some individuals receive In-home Supports and we provide service every single day of the month.

Medicaid eligibility may begin on the first of the month or later in the month depending on the Benefit Plan. Providers are encouraged to verify recipient eligibility prior to the delivery of any goods or services. A provider who chooses to verify eligibility on a periodic basis runs the risk of missing changes in eligibility. While we do not mandate a specific period of time, minimally, monthly verifications should be conducted for those recipients who receive routine goods or services; however, even with frequent verification if eligibility changed between verifications, the responsibility/risk is on the provider.

- How do we know if an individual has been provided products by another provider in the same month we are being asked to ship? How do you avoid double shipping? Medicaid eligibility does not tell us if products have been shipped for the month already?

It looks like you are a Developmental Disabilities waiver provider. The recipient should have a support coordinator, and the support coordinator should be coordinating who provides the supplies (and, hopefully, by default only allowing one provider to supply the items). Also you can contact the local Agency for Persons with Disabilities area office, or contact the family directly to find this information. Please find a link to APD area offices: http://apd.myflorida.com/

- Is there any other way to verify if a person is signed onto the Med Waiver program, when it does not show up on Medicaid verification print out from FMMIS website?

There are no consistent indicators to show that a recipient is receiving services through a Home and Community Based waiver. Please contact your Medicaid Area Office if you need assistance with identifying recipients receiving waiver services.

- How can we get access to the FMMIS? Can support coordinators with various programs such as Head Start programs, Early learning Coalition including Early Steps, Healthy Start, and VPK, access eligibility portals to identify and assist a family to streamline access to care. If so who would they contact?

Access to the actual FMMIS system is limited to state government users and the Medicaid fiscal agent. Enrolled Medicaid providers can use sources that obtain information from the FMMIS database.
These would be the fiscal agent’s web portal, the Automated Voice Response System (AVRS) or one of the Medicaid eligibility vendors. You can find the list of the approved M.E.V.S. vendors at the link below. 
http://portal.flmmis.com/FLPublic/ProviderEDI/ProviderEDI_MEVSVendorList/tabid/63/Default.aspx. Access to these verification methods are for enrolled Medicaid providers only. This information is considered Protected Health Information under federal HIPAA regulations and should only be used as allowed by those regulations.

- We repeatedly encounter clients that are receiving case management services with our organization and then enroll in a Medicaid Waiver program. Despite our efforts to verify Medicaid eligibility, there does not appear to be any flags on the FMMIS system. We are often unaware until months later when we receive notice from AHCA that we need to reimburse for services we provided. We are a large community mental health network and have not been able to identify an efficient way to capture this information. Any help would be greatly appreciated.

As a case manager, it is critical that you be able to coordinate the supports and services your clients receive. Regularly asking your clients about other services and people assisting them can help identify waiver enrollment. In addition, you can contact the Medicaid Area Office for your county and ask that they inform you of any information they have about a recipient’s enrollment in a waiver program. A list of our Area Offices can be found at: 
OVERPAYMENTS

- Overpayment also includes payments received by Medicaid secondary? What should we do?

You can always resubmit the claim as an adjustment and correct the information that caused the overpayment. In the case of Medicare crossover claims, there have been some system issues that have caused overpayment. These are not considered the fault of the provider, but, when the system is fixed, the overpayments will be recouped. You may contact your Area Medicaid Office if you need assistance or for more details.
MEDIPASS

- Is a MediPass authorization number required prior to billing emergency ambulance transportation?

No, transportation services do not require a MediPass authorization.

- Where do I submit claims to MediPass? What is the claim address and can it be submitted electronically? I have contacted different Medicaid provider phone numbers, but I have not received any response back.

Claims for recipients in MediPass are billed just like any other Medicaid claim. Please consult the appropriate billing handbook Florida Medicaid Provider Reimbursement Handbook, CMS-1500, Florida Medicaid Provider Reimbursement Handbook, UB-04; etc. Or contact Provider Support with the Medicaid Fiscal Agent.

You will find the contact information for the fiscal agent, HP Enterprise Services, at: https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Training/032409%20Complete%20General%20Information.pdf. The claims addresses are in the center of the page. The Medicaid Area Office for your county can also assist.

- Is the NPI# the authorization number for MediPass kids? I have some pediatricians who write their NPI# as authorization and others who put their Medicaid #.

No. The National Provider Identifier (NPI) number cannot be used to replace the MediPass authorization number. Providers who are not sure what to use as the MediPass authorization number should contact their Medicaid Area Office. NPI numbers are 10 digits while the MediPass authorization numbers will be 9 digits.

- Do MediPass patients have dental benefits?

Dental services do not require prior approval or referral by the MediPass primary care provider, except in an area with the Prepaid Dental Plan. Some Medicaid HMOs cover dental services. If the HMO does not cover dental services, they may be covered by a Prepaid Dental Plan. Such plans currently operate in Miami-Dade, and they will expand statewide starting in 2012. If the person is not in a prepaid dental plan, the person would be covered under the fee-for-service Dental Services for Children or Dental Services for Adults. Note that the services for adults are very limited. Currently the following health plans cover optional (State Plan) dental services in all of their non-Reform counties of operation: JMH, Healthy Palm Beaches, Integral, Sunshine, and Molina. Beginning on January 1, 2012, only the following health plans will cover optional (State Plan) dental services: Healthy Palm Beaches, Integral, and Molina. Please be careful to request service authorization and to bill accordingly. Information on the implementation of the
Statewide Prepaid Dental Health Plan program is available at the following website: www.AHCA.MyFlorida.com/MedicaidPDHP.
GENERAL QUESTIONS

- We have patients that come from other states and have Medicaid from other states. How do we handle this?

Florida Medicaid cannot be billed for Medicaid recipients from other states. Each state’s Medicaid program operates independently (essentially 50 separate programs). Florida Medicaid beneficiaries are covered for emergency care or prior approved care in other states. You would have to contact the other state’s Medicaid program to find out if they have a similar provision for their beneficiaries who need out-of-state care.

- I understand that Medicaid has an exclusion list.
  1. How can I obtain it?
  2. What format does it come in?
  3. How often is it updated?
  4. Do emails get prompt when the list gets updated?
  5. Do you report to Sanction Check?

Medicaid does not have an exclusion list. However, we encourage providers to make sure that they are not utilizing staff or contractors who are ineligible to participate in the Florida Medicaid program.

Providers may want to (and some are required to) conduct employee screening to ensure that they do not hire staff with criminal or regulatory histories that render them ineligible to participate in the Medicaid program. Staff that have been terminated from the Medicare or Medicaid program in any state, have had licensure action taken against them in any state, or who have criminal convictions (including having plead “no contest” or having had “adjudication withheld”), may not be eligible to participate in the Florida Medicaid program. Minimally, for a provider who employs others that could be enrolled in Medicaid, we would recommend asking the employee whether they have been enrolled in Medicaid before. A provider may also do a public record request for information that may be available in Agency records. Finally, providers who are sanctioned, including the sanctions of suspension or termination, are included in the Agency’s public record (final order) data base.

If there are any further questions about this or other compliance-related matters, please feel free to contact Ms. Kelly Bennett at: Kelly.Bennett@ahca.myflorida.com.
We verify eligibility and we go to bill a claim and it comes back that it has been denied for the following reasons:

1) 0721 (recipient ineligible for date of service-denied after being pended for 14 days awaiting DCF update. If you have eligibility proof contact DCF district office)

2) 4486 (recipient id # not on file- denied after being pended for 14 days awaiting AHCA update)

You should never get either of these denials if the recipient shows as eligible for the date of service. Be sure to check your eligibility information carefully as well as the information on your claims. Providers often get the 4486 error when they try to use the Gold Card number or Social Security Number on the claim instead of the 10-digit Medicaid ID. If this happens, contact your local Medicaid Area Office. You can find a list of the Medicaid Area Offices and contact information on the Medicaid fiscal agent’s Web Portal at: http://mymedicaid-florida.com/.

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On slide 37, what is a swing bed?

A licensed rural hospital with 100 or fewer beds may designate acute care hospital beds as “swing beds.” Swing beds may be used as hospital beds, skilled nursing facility beds, or intermediate care facility beds. This allows a hospital to provide these other types of services when beds in the other facilities are not available. When a bed becomes available, the patient is admitted to the appropriate facility and the bed “swings” back to being an acute care hospital bed.

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If an adult Medicaid patient does not have a visit with a clinician and only comes in requesting a flu shot, are we allowed to bill the patient? There is no face to face with the physician.

Medicaid only covers flu shots for persons under 21. This is a non-covered service for an adult so they would need to be informed beforehand and, if they still want the service, they can be billed.

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My provider type is Mental Health Practitioner. I am a sole proprietor which I think negates me from billing Medicaid directly. If I understand it, I am able to provide services and bill through agencies like Amerigroup and Wellcare but not directly to Medicaid. Please let me know if my understanding is incorrect.

You are correct that you cannot bill Medicaid to be paid directly. Your provider type only allows you to participate as a treating (not a “Pay-To”) provider. Your enrollment method only allows you to be a treating provider with a managed care plan.
• Are clients with MediKids and/or presumptively eligible pregnant women eligible for outpatient behavioral health services? Where can I find more information?

MediKids coverage and presumptively eligible pregnant women (PEPW) coverage do include behavioral health services. Be sure to check the **Community Behavioral Health Services Coverage and Limitations Handbook** for more details, including the minimum age for the specific procedures, since MediKids only covers recipients up to age 4.

• The MS program is determined by the social security agency; which agency determines the Title XIX?

The Department of Children and Families (DCF) also determines eligibility for Title XIX (Medicaid).

• What else can be done if information is provided in DCF view and FMMIS is still showing patient ineligible?

If you have reason to believe that the patient really is eligible and the verification systems are incorrect, please discuss this with your Area Office for your county. Area offices contact information can be found at: [http://mymedicaid-florida.com/](http://mymedicaid-florida.com/).

• Are providers required by Medicaid to call customers prior to an order shipping or service being provided?

Please see the **Florida Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook** for the following policy:

> Recipients’ individual medical supply needs vary from month to month. Medical supply quantities must not exceed the individual recipient’s one month’s usage. The over-provision of medical supplies by DME and medical supply providers and the stockpiling of unnecessary medical supplies by recipients are discouraged. Unless consumable medical supplies specifically prescribed for infusion, wound or nutritional therapy are furnished by the visiting home health agency staff, the automatic refilling of consumable supplies by a DME provider is prohibited. The refilled amount supplied may not exceed the number and frequency ordered by the authorized prescriber. Documentation of each request for refill must be maintained in the recipient’s file. Placing a recipient on automatic supplying or replenishment until the prescription is all used or the recipient voluntarily discontinues services is prohibited.

• How can Therapy Providers (type 83) know when a recipient was last evaluated or re-evaluated for any of the three services (Speech, Occupational, Physical therapy)? This information is needed because sometimes the patient does not know the information, or in
some cases the PCP does not give us accurate information regarding last date of evaluation, and it is the only way of knowing how to start the treatment with new patients.

If you cannot get the information from the recipient or the family, you will need to contact your Medicaid Area Office. They search for any paid claims for the procedure code for the evaluation. Note that this is not 100% reliable since providers have 12 months from the date of service to bill their claims.

- If we admit a child that has Medicaid but, it’s under a different last name, how would this affect the billing process?

It is not uncommon for this to happen, but you should confirm the other identifying information on the recipient (SS#, DOB, etc.) to be sure that you have the correct person before billing. The fiscal agent can assist you at 800-289-7799 or your local Medicaid Area Office.

- I am with an ambulance transport company. My question is if we have a transport with a patient in an emergent situation, what recourse do we have to bill when many times Medicaid comes in later after the transport is done?

As long as the Medicaid coverage includes the date of the transport, you can still submit your claim. If the date of service is within 12 months, you can use your normal billing procedure. If the date of service is beyond 12 months, you would need to bill with a paper claim and send the claim through the Medicaid Area Office for your county. They may also ask you to provide verification that the Medicaid eligibility was a late update to the recipient’s file.

- If the provider sees a patient in the hospital and does surgery and needs a follow up in the office and the provider is not a provider in his practice, how do we obtain an authorization?

For patients managed under MediPass, you will need to contact the MediPass Primary Care Provider (PCP). When you verify eligibility you can find the name and telephone number of the PCP. If the person is in another type of managed care plan, the plan’s name and telephone number will be listed. You would contact the plan to find out if you can perform the service or if you will need to refer the recipient to a physician in the plan’s network.

- On the eligibility screen on the web portal, how does the billing information under recipient information section get on there about the dentures and the glasses?

The information on service usage is taken from claims paid through the system. It may not be 100% complete since providers have 12 months to bill for services. Whenever possible, you should ask the recipient if he/she has had the service from another provider.
How do we go about getting authorization from PCP for therapy services?

You will need to contact the recipient’s MediPass PCP. This can be found when you verify eligibility. Note that you will also need to obtain prior authorization from eQHealth Solutions.

What is a Point of Sale (POS) device?

These are devices supplied by MEVS (Medicaid Eligibility Verification Systems) vendors. They are similar to the small box-like devices used in stores for credit card or debit card purchases. When using a POS device the Medicaid card can be swiped through the terminal’s card reader slot, or the recipient access information can be entered by hand. You can find the list of the approved MEVS vendors at the link below.


What is the difference between SSA and SSI?

SSA is the Federal Social Security Administration. SSI is Supplemental Security Income, a program for low-income, disabled persons as determined by the Social Security Administration. The SSA also determines eligibility for social security disability benefits. This does not automatically include Florida Medicaid coverage as do SSI benefits. You should contact www.hhs.gov for more information.

I have heard that there is one item of information on the automated-phone line that often is erroneous: when one checks the eligibility of a recipient who is living in a skilled nursing facility under ICP (nursing home) Medicaid, the phone line always says the recipient was NOT in a nursing home on the date of service.

Prior to billing Medicaid, nursing facilities must have WRITTEN documentation on file from DCF that the recipient has been determined ICP eligible for the date(s) of service billed. This is mandatory even for SSI recipients. The only exception to this policy is nursing facility providers may bill Medicaid for Medicare Part A coinsurances (level of care "X" claims) and Medicare B Crossover claims when the recipient is not eligible for ICP Medicaid but is eligible for Qualified Medicare Beneficiary (QMB). To answer the question the system responds that way because if you verify eligibility for a nursing home resident for today’s date the nursing home has not yet billed for services for today’s date so to the system doesn’t know the recipient is a resident of a nursing home. If you verify eligibility for a past date that a facility has already billed for the system will respond that the recipient is in a nursing home.
- What are the income limits for establishing eligibility? 100% poverty line? 200%, etc?

The limits vary according to household size and coverage group. Most coverage groups have an income limit below the federal poverty level, but some such as children under age 5 and pregnant women, have higher income limits. Persons who want to find out if they may be eligible for benefits can use the Prescreening Tool at this web site: https://DCF-access.dcf.state.fl.us/access2florida/prescreening/welcome.do?performAction=init&mode=Inter

- Can a person who has limited Medicaid benefits be eligible for dental benefits? Would such a person always be ineligible for dental benefits?

You would need to look at limits of the specific benefit plan. Contact the Medicaid Area Office for your county for assistance.

- I have noticed that the program code “MS” is for an SSI Benefit Plan and a Title XIX Benefit Plan, does the rule of Hierarchy take effect in this case? If so, which is the higher?

Both of these program codes are full Medicaid plans. The FMMIS system does indicate that SSI is the higher plan.

- Can you tell me what MS Full Medicaid or MC Full Medicaid means and does it indicate the recipient is still full Medicaid if they have "Managed Care" on the web portal?

MS is a full Medicaid coverage code for persons who are eligible for the federal Supplemental Security Income program. We do not have “MC” as a code, but our list of codes has MCAE, MCAN, MCE, MCFE and MCFN. These are all full Medicaid coverage codes. The recipient is still full Medicaid if they are also enrolled in managed care.